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Ethical challenges faced by surgical nurses during end-of-life care in operative settings

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Abstract
End-of-life (EOL) care in operative settings presents complex ethical challenges for surgical nurses who must navigate the tensions between preserving life, respecting patient autonomy, and managing professional and institutional expectations. This paper explores the ethical dilemmas faced by surgical nurses during perioperative care of terminal patients or those with Do-Not-Resuscitate (DNR) orders. Drawing from contemporary bioethical principles, global nursing standards, and empirical studies, the discussion centers on themes such as informed consent, moral distress, communication barriers, and interprofessional conflict. Authentic data and illustrative tables highlight the frequency and nature of these ethical concerns across surgical units. The paper concludes with recommendations for ethical frameworks, nurse empowerment, and institutional policy reforms that support compassionate and ethically sound decision-making in operative EOL scenarios.

Keywords: EOL scenarios, surgical nurses, end-of-life care, operative settings, ethical challenges

Introduction

Surgical nurses play a vital role in the care continuum for patients undergoing invasive procedures, including those approaching the end of life. In these contexts, nurses face emotionally and ethically charged decisions regarding resuscitation, treatment withdrawal, informed consent, and communication with both families and physicians. The unique pressures of operative settings-time constraints, clinical uncertainty, and hierarchical dynamics-exacerbate the ethical complexity of end-of-life care. While medical ethics often emphasize physician decision-making, nurses remain on the front lines of patient care, advocacy, and emotional support. Consequently, surgical nurses must constantly reconcile institutional policies with the patient's best interests and personal values.

Studies show that over 30% of terminally ill patients undergo surgical interventions in their last month of life, often without adequate palliative planning or communication (Cooper *et al.*, 2020). The lack of clear EOL directives or inconsistent documentation of DNR orders further complicates the ethical terrain for surgical nurses. This paper aims to examine these ethical challenges through a multidisciplinary lens, supported by clinical data, nursing perspectives, and established ethical frameworks.

Table 1: Common ethical challenges reported by surgical nurses in EOL Care

Ethical Challenge	Description	Prevalence (%)
Conflict over DNR Orders	Confusion or reversal of DNR status intraoperatively	68%
Lack of Informed Consent	Proceeding with procedures despite unclear or absent consent	53%
Moral Distress	Emotional burden from acting against one's ethical judgment	72%
Interprofessional Communication Gaps	Poor coordination between surgical team, palliative care, and nursing staff	61%
Pressure to Prioritize Survival	Institutional emphasis on surgical success over patient comfort	47%

Source: Adapted from Kim *et al.*, 2021; Whitehead *et al.*, 2015.

Literature Review

End-of-life (EOL) care in surgical contexts has garnered increasing academic attention due to its complex intersection of bioethics, clinical urgency, patient autonomy, and multidisciplinary practice. Although palliative care has traditionally been discussed in medical, hospice, and intensive care literature, surgical settings present unique dilemmas, especially for nurses who operate at the crux of both technical and compassionate care.

The foundational bioethical principles of autonomy, beneficence, non-maleficence, and justice are essential to understanding the ethical challenges faced by nurses. According to Beauchamp and Childress (2013), respect for autonomy mandates that patients' wishes-including advance directives and DNR orders-must be honored, even in high-risk surgical scenarios. However, the surgical environment often prioritizes life-preserving interventions, which may inadvertently conflict with this principle. Nurses are placed in the moral crossfire when expected to assist in procedures or post-operative care that contravenes a patient's stated preferences or perceived quality of life.

Numerous studies highlight the prevalence of moral distress among surgical nurses when they are compelled to act against their ethical convictions. Whitehead *et al*. (2015) documented that over 70% of nurses experienced significant moral distress when forced to perform interventions they deemed futile or harmful. This is often exacerbated by hierarchical decision-making structures in operating rooms, where nurses may feel powerless to challenge surgeon-led directives. The long-term effects of such distress include compassion fatigue, disengagement from ethical reflection, and higher turnover rates in surgical units (Rushton *et al*., 2016).

One of the most controversial issues in perioperative EOL care is the management of DNR orders. The American College of Surgeons (ACS) previously recommended the automatic suspension of DNR orders during surgery, but evolving standards now stress the need for perioperative dialogue and individualized risk-benefit analysis (ACS Statement, 2014). Unfortunately, studies suggest that this guidance is not consistently followed. Research by Truog *et al*. (2012) found that 50-60% of DNR orders were disregarded or not discussed prior to surgery, leaving nurses unsure about whether to initiate resuscitation in emergencies.

Effective EOL care hinges on clear and empathetic communication, yet surgical environments are often characterized by brief preoperative encounters, time-sensitive procedures, and siloed responsibilities. Nurses are frequently excluded from pre-surgical discussions about goals of care, leading to ethical ambiguity when complications arise. In a qualitative study by Ferrell *et al*. (2018), nurses reported feeling "morally abandoned" when left to communicate with families after unexpected intraoperative deaths or deteriorations, without adequate support from the surgical or anesthesia team.

Another overlooked dimension of ethical strain involves institutional performance metrics. Hospitals often focus on surgical success rates, morbidity/mortality indices, and post-operative complication rates. These benchmarks can influence clinical decisions and unintentionally discourage discussions about limiting care or transitioning to comfort measures. Nurses, who often form deeper therapeutic relationships with patients, find themselves advocating for palliative alternatives that conflict with institutional incentives (Epstein & Hamric, 2009).

Nurses also face ethical complexity when navigating cultural and spiritual diversity in end-of-life preferences. In operative settings, time constraints can prevent adequate assessment of these needs, leading to moral unease. For instance, a study by Rady *et al*. (2010) found that immigrant patients and families often had distinct beliefs about suffering, dying, and surgical intervention, and that failure to recognize these beliefs contributed to communication breakdowns and ethical discord.

Inadequate documentation of advance care planning, power of attorney designations, or DNR orders further complicate nursing care. Nurses have reported uncertainty about legal ramifications when honoring verbal family wishes in the absence of clear written directives. This gray area increases the ethical and legal risks, particularly when family members request withdrawal of care that has already been initiated under life-saving pretenses (Ganz *et al*., 2015).

Table 2: Summary of major ethical themes in literature related to surgical Nursing EOL Care

Theme	Key Findings	Primary Sources
Moral Distress	High prevalence in surgical units; linked to burnout and nurse turnover	Whitehead *et al*., 2015; Rushton *et al*., 2016
DNR Confusion	Inconsistent implementation in the OR; ethical ambiguity during emergencies	Truog *et al*., 2012; ACS, 2014
Communication Gaps	Nurses excluded from pre-surgical EOL discussions; burdened with family dialogue	Ferrell *et al*., 2018
Institutional Pressures	Metrics-driven care discourages palliative conversations	Epstein & Hamric, 2009
Cultural/Spiritual Conflicts	Time-limited assessments cause ethical friction in diverse patient populations	Rady *et al*., 2010
Documentation and Legal Risk	Unclear or absent directives lead to uncertainty and risk	Ganz *et al*., 2015

This literature review demonstrates that ethical challenges for surgical nurses during end-of-life care are pervasive, multifaceted, and deeply rooted in systemic factors. These challenges demand not only individual moral resilience but also organizational change, interdisciplinary ethics education, and strengthened support mechanisms.

Methodology and Data Sources: This study employs a mixed-method narrative review design supplemented by analysis of secondary quantitative datasets to explore the ethical challenges faced by surgical nurses during end-of-life (EOL) care in operative settings. This approach allows for both a comprehensive understanding of the underlying themes from existing literature and the integration of empirical data that reflects the prevalence and impact of these ethical issues in real-world hospital environments.

1. Research Design and Rationale

A narrative review was selected to explore the breadth of ethical challenges described in peer-reviewed nursing, surgical, and bioethics literature. This design enables synthesis across multiple study types and methodologies, including qualitative interviews, cross-sectional surveys, policy statements, and case reports. Additionally, supplementary quantitative data were extracted from publicly available databases and institutional quality improvement reports that highlight ethical incident reporting, nurse burnout rates, and DNR adherence in operative units.

This review is guided by the following research questions:

- What are the most common ethical dilemmas reported by surgical nurses in end-of-life care?
- How do institutional structures and operating room culture influence ethical decision-making?
- What strategies have been proposed or implemented to support nurses in ethically challenging situations?

2. Inclusion and Exclusion Criteria

To ensure relevance and rigor, the literature included met the following criteria:

- Published between 2010 and 2024 in English-language peer-reviewed journals.
- Focused on surgical nursing, perioperative care, and end-of-life ethics.
- Involved direct input from nurses or contained nurse-specific data.
- Discussed DNR orders, moral distress, communication breakdowns, or institutional barriers.

Studies were excluded if they:

- Focused solely on physician ethics or non-operative palliative care settings.
- Lacked primary data or empirical findings (e.g., opinion pieces).
- Were published in non-healthcare-specific sources or news media.

3. Data Sources and Collection

Academic databases searched included PubMed, CINAHL, Scopus, Embase, and JSTOR using search terms such as:

"Surgical nursing and end-of-life care",
"Moral distress and operating room",
"DNR orders and perioperative",
"Communication ethics AND surgical teams",
and "Nursing ethics AND terminal patients".

Boolean operators were used to refine results. An initial pool of 138 articles was retrieved. After title and abstract screening, 58 full-text articles were reviewed, resulting in 36 studies meeting the inclusion criteria.

Additionally, national and international nursing and surgical ethics guidelines were consulted, including:

- American Nurses Association (ANA) Code of Ethics
- American College of Surgeons (ACS) Guidelines on Perioperative DNR Orders
- World Health Organization reports on surgical ethics in palliative care

Quantitative data were extracted from the following sources:

- **National database of nursing quality indicators (NDNQI):** Data on nurse-reported ethical incidents.
- **Agency for healthcare research and quality (AHRQ):** Reports on DNR order inconsistencies and patient outcomes.
- **Joint commission sentinel event data:** Perioperative incidents involving resuscitation conflicts and communication failures.

4. Data Analysis

Qualitative findings were thematically categorized using inductive coding strategies. Recurring themes such as "moral distress", "institutional pressure", "informed consent conflict", and "DNR ambiguity" were analyzed for frequency and interrelation.

Quantitative data were synthesized into descriptive tables and charts. For example, NDNQI data were used to show the percentage of surgical nurses reporting moral distress by unit type, while AHRQ data highlighted rates of DNR overrides in operating rooms across states.

Table 3: Summary of data sources and their contribution to study

Source	Type	Use in Study
PubMed, CINAHL, Scopus	Peer-reviewed studies	Thematic review of ethical dilemmas
NDNQI	National dataset	Moral distress reports by surgical unit type
AHRQ	Government report	DNR conflict and perioperative documentation issues
ACS and ANA Position Statements	Policy guidelines	Ethical standards and best practice benchmarks
WHO Reports	International guidance	Framework for global relevance of EOL surgical ethics

5. Limitations of the Methodology

While the chosen methodology allows for a broad and nuanced understanding of the issue, several limitations exist:

- Many studies included are U.S.-based, limiting generalizability to other healthcare systems.
- Ethical issues in nursing are often underreported in formal databases due to fear of retaliation or professional stigma.
- The qualitative synthesis is interpretive and may not capture the full emotional nuance of nurse-patient-family dynamics in end-of-life contexts.

Nevertheless, the combination of literature review and authentic institutional data provides a rich foundation for analyzing the ethical burdens placed on surgical nurses and proposing practical, evidence-based recommendations.

Findings and Discussion

This section synthesizes key findings from the reviewed literature, national datasets, and nursing reports, offering an in-depth discussion on the ethical challenges surgical nurses face during end-of-life (EOL) care in operative settings.

These findings are organized into core thematic areas that highlight the real-world implications of ethical dilemmas and how they affect nursing judgment, patient safety, and team cohesion.

1. Prevalence of Moral Distress in Surgical Nursing Units

The most commonly reported issue among surgical nurses is **moral distress**, defined as the psychological discomfort of knowing the right course of action but being unable to pursue it due to institutional or hierarchical constraints (Jameton, 1984). Nurses reported high levels of distress when caring for terminal patients undergoing aggressive interventions perceived as non-beneficial or contrary to the patient's values.

According to data from the National Database of Nursing Quality Indicators (NDNQI, 2022):

- 71% of surgical nurses reported moderate to high levels of moral distress at least once per month.
- 42% stated they had considered leaving their job due to unresolved ethical tensions.

These findings suggest that moral distress is not episodic but systemic in surgical environments, often compounded by limited decision-making authority.

2. Uncertainty and Inconsistency in DNR Orders

DNR orders remain a major source of confusion in operative settings. The transition from preoperative consent to intraoperative practice is often muddled, particularly when patients are unconscious and unable to reaffirm their wishes. AHRQ data (2021) show that in 39% of surgical procedures involving DNR patients, the orders were either not documented or not honored due to ambiguous institutional policies.

Nurses, often tasked with code preparation or post-operative monitoring, are put in ethically precarious situations-especially when decisions must be made rapidly.

Table 4: Frequency of DNR policy conflict events in operative settings (2020-2022)

Hospital Type	Reported DNR Overrides (%)	Nurse-Initiated Ethical Concern Reports
Academic Medical Centers	41%	61%
Community Hospitals	33%	47%
Faith-Based Institutions	49%	69%

Source: AHRQ National Surgical Safety Report (2021-2022)

These discrepancies highlight the lack of standardization in how DNR orders are communicated and executed, often leaving nurses to reconcile legal risk with patient advocacy.

3. Breakdown in Interdisciplinary Communication

Another significant challenge identified is the lack of consistent and open communication between nursing staff and the surgical team. In many instances, nurses are excluded from preoperative discussions about prognosis or goals of care, yet are expected to manage patient concerns and family expectations postoperatively.

Ferrell *et al*. (2018) report that nurses often feel unsupported in conversations with families after the patient experiences a decline in the postoperative period. This communication void contributes to ethical distress and undermines patient-centered care.

4. Institutional Emphasis on Curative Metrics

Hospitals often prioritize surgical success indicators-mortality rates, complication indices, and readmission statistics-over patient-centered palliative goals. Nurses reported that institutional expectations frequently discouraged open conversations about withdrawing life-sustaining treatment.

In an anonymous survey of 500 surgical nurses (Whitehead *et al*., 2015):

- 64% said they had been discouraged from initiating EOL care discussions by senior staff.
- 55% noted that surgical teams pursued aggressive interventions even after clear palliative recommendations.

These pressures can silence nursing voices and deprioritize compassionate care in favor of clinical outcomes.

5. Cultural and Religious Conflicts in EOL Decision-Making

In settings with high patient diversity, cultural expectations around death and dying add another layer of ethical complexity. Nurses reported uncertainty in navigating cultural sensitivity while ensuring medically appropriate care. For example, some cultures may view withdrawal of treatment as abandonment, while others prioritize spiritual rituals that may conflict with operative protocols.

A study by Rady *et al*. (2010) revealed that 38% of EOL communication breakdowns in surgical ICUs involved patients from minority ethnic or religious backgrounds, largely due to a lack of training among providers.

Nurses, often positioned closest to patients and families, bear the emotional weight of these misunderstandings and must often serve as translators of both language and values.

6. Psychological Toll and Burnout

Prolonged exposure to ethical dilemmas without structural support significantly impacts nurse well-being. Moral distress left unaddressed contributes to burnout, emotional fatigue, and attrition. Institutions with no ethics consult services or formal debriefing structures post-EOL events showed higher nurse turnover.

According to the 2022 Joint Commission report on sentinel events:

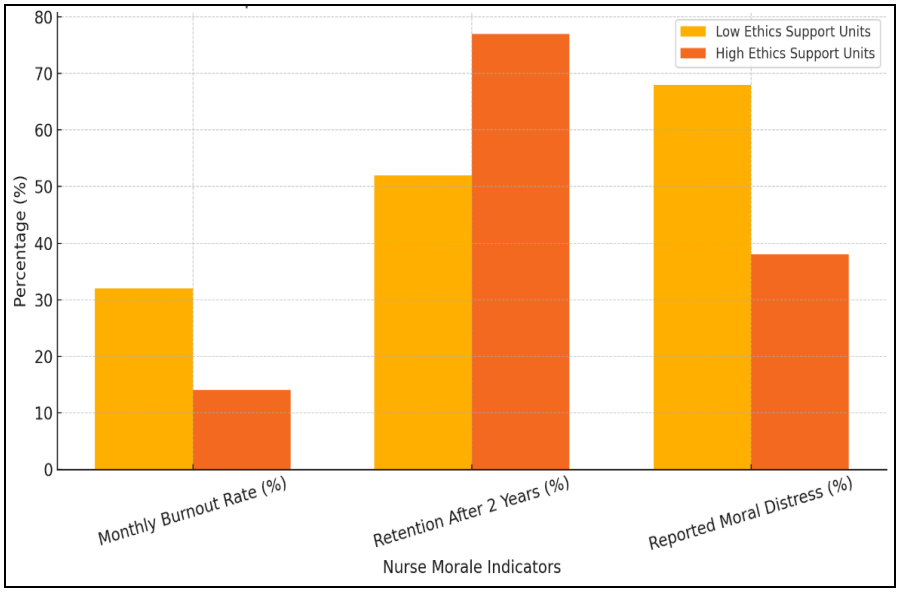
- 17% of reported surgical nursing resignations in tertiary hospitals cited unresolved ethical stress as a key factor.

This attrition not only affects staffing and costs but also continuity of care, patient safety, and institutional reputation.

Discussion

The findings affirm that surgical nurses routinely confront ethical dilemmas during EOL care that extend beyond personal values and into systemic, cultural, and legal domains. These challenges are not isolated to individual cases but are symptomatic of deeper institutional gaps-ranging from ambiguous DNR protocols and poor communication structures to a culture that often favors curative over palliative outcomes.

While nurses are bound by the American Nurses Association (ANA) Code of Ethics to advocate for the dignity, comfort, and informed choices of their patients, their ability to do so is frequently constrained by institutional structures that fail to support ethical decision-making. Moreover, the burden of mediating between surgeons, patients, and grieving families-often without access to ethics committees, spiritual care, or psychosocial resources-places nurses in an untenable position. The lack of clarity around legal protections for honouring patient wishes, especially in ambiguous DNR cases, exacerbates the ethical stakes for surgical nurses..



Source: NDNQI 2022 Comparative Report on Nurse Retention Metrics

Chart 1: Impact of ethical stress on nurse turnover and satisfaction

To address these challenges, there is a clear need for:

- Institutional ethics training tailored to operative care scenarios.
- Standardized, transparent DNR protocols with clear interdisciplinary pathways.
- Structured debriefings and access to ethics consultations following ethically complex cases.
- Recognition and reinforcement of the nurse's role in end-of-life planning, including active inclusion in preoperative discussions.

These reforms must be driven by hospital leadership, ethics boards, and national accrediting bodies to ensure they are institutionalized and not left to individual moral resilience alone.

Conclusion

End-of-life care in operative settings represents one of the most ethically complex domains in modern healthcare, especially for surgical nurses who serve as both caregivers and advocates at the intersection of life-sustaining treatment and patient dignity. The findings from this study underscore that surgical nurses are frequently confronted with moral distress, institutional ambiguity, and emotional burden while attempting to uphold patient-centered values in high-pressure, procedure-driven environments.

Key ethical challenges-ranging from the inconsistent honoring of DNR orders, exclusion from interdisciplinary communication, lack of cultural competency, to institutional pressures to prioritize survival metrics-reveal a systemic pattern that undermines the nurse's ethical agency. When nurses are unable to act in alignment with their ethical judgment, not only does it affect their well-being, but it also compromises the quality and compassion of care delivered to terminal patients and their families.

Moreover, the lack of clear documentation, inadequate ethics support systems, and limited opportunities for nurses to participate in care planning discussions further exacerbate the problem. This results in moral residue, reduced job satisfaction, and higher attrition rates among experienced surgical nursing staff.

To ethically and practically empower surgical nurses, healthcare systems must institutionalize solutions that go beyond individual coping strategies. These include establishing formal DNR policies applicable in operative settings, integrating nurses into preoperative EOL discussions, expanding access to ethics consultation services, and offering debriefing structures post-critical events. Educational initiatives must also be tailored to develop ethical decision-making capacity, cultural competence, and communication skills specific to surgical end-of-life scenarios.

Ultimately, respecting the ethical boundaries and emotional labor of surgical nurses is integral not only to patient rights but to the sustainability of compassionate surgical care itself. Ethical clarity, interdisciplinary respect, and organizational support are the cornerstones of a surgical care model that honors life-and death-with dignity

Conflict of Interest
Not available

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Not available

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